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TAKING THE BITE OUT OF DENTAL READINESS: ASSESSING READINESS IN THE NATIONAL GUARD AND THE RESERVES

BY

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ABSTRACT

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The activation and deployment of the National Guard and Reserves have increased since September 11, 2001. There is an emphasis on keeping those units manned, equipped, trained, and ready for future deployments and cases of national contingencies. Medical readiness plays a critical role in service members being able to accomplish their mission. Dental readiness is one essential part of medical readiness, and therefore is of national importance. The Army and Marine Corps are not meeting dental readiness goals for their reserve components. There is a description for each Services ready rotations and mobilization of their Reserve and National Guard forces. This paper examines the dental readiness of Reserve and National Guard units, discusses some issues related to service members seeking dental care, and explores the role of those issues in military readiness. Moreover, the paper describes programs available to the Services and proposes solutions to mitigate poor dental readiness in order to meet these challenges of in the National Guard and Reserve forces. Each Service needs to use the resources identified in this paper to improve dental readiness.

TAKING THE BITE OUT OF DENTAL READINESS: ASSESSING READINESS IN THE NATIONAL GUARD AND THE RESERVES

"Every tooth in a man's head is more valuable than a diamond,"

Miguel de Cervantes, Don Quixote, 1605

"You're not healthy without good oral health" -Dr. C. Everett Koop, Former United States Surgeon General, 1982-1989 , Chairman, Oral Health 2000[1]

The United States Surgeon General was not the first to articulate the realization that good oral health is a critical component of overall health. As the chief medical doctor of the United States near the end of the last century, he understood and put an added emphasis on the notion of good oral health for the future and launched a program to bring awareness about oral health to the nation. Military planners have long known that diseases have the potential to incapacitate more war fighters than combat injuries. The health of United States armed forces personnel is a critical component of the strength, readiness, and effectiveness of the military's ability to meet disasters in the United States and threats to peace, human rights abuses, and other global disasters around the world.[2] High medical readiness of our forces helps prevent unexpected medical or dental emergencies during training and operational deployments. Studies have demonstrated a significantly lower incidence of dental emergencies and lower disease non-battle injury (DNBI) rates among those who deploy without dental disease.[3] Despite updated Department of Defense emphasis and policies on dental readiness, poor dental readiness continues to plague the Services as evident in our Reserve and National Guard forces today as they mobilize for their missions in support of Operations Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) campaigns.

The House Armed Services Committee (HASC), Oversight and Investigations in Support of the Military Personnel Subcommittee held a hearing on the challenges associated with achieving full dental readiness in the reserve component in April 2008. Officials from Dental Care Branch TRICARE Management Activity of Office of the Secretary of Defense (Health Affairs); Reserve Component Mobilization and Demobilization Operations, U.S. Army Dental Command; Reserve Affairs Officer, U.S. Navy Dental Corps; Mobilization Assistant to the Air Force Assistant Surgeon General, Dental Services, Office of the Surgeon General, U.S. Air Force; and the Chief Surgeon, Army National Guard testified.[4]

In his opening statement, Chairman, Vic Snyder (D, Arkansas), identified challenges associated with achieving full dental readiness in the reserve component. He stated, "DOD (Department of Defense) has said that 95 percent of military personnel, active and reserve, should fall into the Class 1 or 2 dental fitness categories, meaning that they are healthy enough to deploy."[5] Comparing the readiness among the Services, he went on to add "…the Army and Marine Corps have struggled the most."[6] Only 43.2 percent of the Army National Guard and 50.6 percent of the Army Reserve is currently ready to deploy. Only 77.7 percent of the Marine Corps Reserve is ready to deploy."[7] He stated, "None of the Services are meeting the DOD goal."[8] "This a public health issue and a readiness issue."[9] Chairman Snyder emphasized, "The most important thing that they (service members) bring to the table is their health, the medical and dental readiness of the force."[10] "Oral health is an often overlooked, but extremely important aspect of overall pre-deployment readiness."[11]

Some of the conclusions announced in the Findings and Recommendations following that HASC, Oversight and Investigations in Support of the Military Personnel Subcommittee hearing include “Dental readiness of the reserve component is dramatically lower than that of the active duty force*.* Most reserve component members do not take advantage of the TRICARE Dental Program (TDP)”[12] prior to mobilization. “…members of the reserve component are eligible for a dental examination from a military dentist or a civilian dentist paid for by the military, but may only receive treatment after being alerted for mobilization.”[13] The HASC, Oversight and Investigations in Support of the Military Personnel Subcommittee hearing also found that “States take an individual approach to improving the dental readiness of their National Guard.”[14]

History of Dental Readiness

The DOD identified the need to increase dental readiness following reports made after the Persian Gulf War.[15] The findings of the HASC, Oversight and Investigations in Support of the Military Personnel Subcommittee are not new and there were problems back during the Persian Gulf War.[16] As the senior medical policy maker for Department of Defense, the Assistant Secretary of Defense (Health Affairs) has addressed the issue of poor dental readiness rates on several occasions and published policies and guidelines for classifying medical and dental readiness and has promulgated specific instructions on carrying out those guidelines.[17] These policies emphasize the active component but finally cover all components in a Department of Defense Instruction published in 2006.[18] The Assistant Secretary of Defense (Health Affairs) published the Dental Fitness Classification guidelines for the standardization of Oral Health and Readiness Classifications for the first time in 1996in the reserve.[19] In 1998, Department

of Defense for Health Affairs policy defined the frequency of periodic examinations and standards for overseas assignment and deployability for both the active and reserve forces.[20] Although the policy created an examination requirement for all DOD reserve component personnel, it did not address a funding method to meet that requirement.[21] He established the Oral Health Classifications as a policy for the Army, Navy, and Air Force in 2002.[22] A Department of Defense Instruction released in 2006 directs all components of the military Services to use the same dental fitness classification system to assess and monitor dental readiness.[23] In 2006, the Assistant Secretary of Defense (Health Affairs) finalized and reaffirmed the 2002 policy for classification of patients with respect to dental disease and established a target of 95 percent dental readiness goal for Active Duty Service members and for Selective Reserve personnel.[24]

Every military Service has its share of untimely dental emergencies both during training and actual deployments. Seven percent of medical evacuations from US Navy ships and submarines in a 1995 study of the evacuation experience during that conflict were due to non-injury related dental emergencies.[25] In addition, dental problems accounted for 6.9–9.3 percent of all medical evacuations from submarines between 1991 and 1999.[26] Army reserve component units mobilized between 1997 and 2001 presented to mobilization platforms with significant dental disease rates between 14-36 percent.[27] Class 3 and 4 rates showed little improvement with Army reserve component Soldiers presenting to mobilization platforms from January-August 2002 with DFC 3 rates of 25 percent.[28] During recent operations in Bosnia, Chaffin et al. reports between 15-17 percent of soldier experienced dental emergencies per year.[29] Another staggering statistic on the health of recruits comes from a 2008 article by York et al. that more than

50 percent of the recruits began their military service in dental class 3.[30] The recent attention that has identified poor dental readiness in our reserve component is not new. Poor medical and dental readiness was evident when it occurred during the First Gulf War. At that time over 150,000 Army reserve component, soldiers were mobilized for active duty.[31] The American Forces Information Services News Articles quoted an Army Reserve source stating, "Roughly 35 to 45 percent of Army Reservists activated during the Gulf War needed dental work before they could deploy."[32 33] The Department of Defense sought funding from Congress to ensure that combat forces could remain in a high state of medical readiness and preparedness throughout the late 1990s. Bodenheim in his article on the Army Reserve Components dental readiness - Historical Review Since the First Gulf War pointed out "…by the close of the 20th century, the introduction of the Reserve Component Tricare Dental Program provided the first funded program for Army Reserve Component dental readiness."[34]

Dental Fitness Classification Guidelines

In order for the Reserve/Guard to comply with the new Assistant Secretary of Defense (Health Affairs) policies, dental readiness must be quantified. The Department of Defense oral health and readiness classification system[35] establishes four dental fitness classifications (DFC). DFC 1 identifies patients with a current (meaning within the last 12 months) dental examination who do not require any dental treatment or reevaluation. DFC 1 patients are worldwide deployable. DFC 2 are patients with a current dental examination who require non-urgent or routine dental treatment or reevaluation for oral conditions that are unlikely to result in dental emergencies. (a consensus definition: dental emergency: a condition of oral disease, trauma or loss of

function, or other concern that causes a patient to seek immediate dental treatment.[36]) within the next twelve months. DFC 2 patients are worldwide deployable. DFC 3 Patients are those who require urgent or emergency dental treatment. DFC 3 patients normally are not considered to be worldwide deployable. DFC 4 patients require a periodic dental examination or patients with unknown dental classifications because they have not been examined within the past twelve months. DFC 4 patients normally are not considered to be worldwide deployable.[37] Although the Department of Defense (Health Affairs) classification instructions for all Services include this broad overview there are Service specific interpretations that may lead to inconsistency in interpretation of readiness statistics for each dental classification across the Services.

Reserve Component Structure

In order to understand the medical and dental readiness challenges of the reserve component, a full understanding of the reserve component structure is important. “Reserve and National Guard” refers to members of the Army National Guard, Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard, Air Force Reserve and U.S. Coast Guard Reserve. Title 10 of the United States Code, states that the purpose of the reserve component is to provide trained units and qualified persons for active duty, in time of war or national emergency, and at such other times as the national security may require to fill the needs of the armed forces whenever more units and persons are needed than are in the regular components.[38] The reserve component of the United States military is divided into the National Guard and the Services Reserve. The National Guard is a joint reserve component of the United States Army and Air Force composed of two subcomponents: the Army National

Guard of the United States Army and the Air National Guard of the United States Air Force. Established under Title 10 and Title 32 of the United States Code, the National Guard is divided up into units belonging to each State, the Commonwealth of Puerto Rico, the District of Columbia, Guam, and the Virgin Islands includes such members of the staff corps corresponding to the staff corps of the Army as the Secretary of the Army.[39] While in reserve status, National Guard units are under the command of the state or territory governor and under the control of the state or territory adjutants general.[40] [41] The National Guard may be called to active duty by the state governors to respond to domestic emergencies or disasters, such as those caused by hurricanes, floods, and earthquakes.[42] Whenever Congress determines that more military units are needed for national security than are in the regular components of the ground and air forces, the Army National Guard and the Air National Guard may be ordered to active Federal duty by the President.[43] Because of the possibility of the National Guard may be ordered to active Federal Duty and then deployed, the medical and dental readiness of Guard units must be high. Each state Adjutant General under the direction of the state governor has the responsibility for readiness of their National Guard units including dental readiness.

The Selected Reserve (SELRES) is a term for active Reserve members who participate in drill on a regular basis, which is typically one weekend per month and for two continuous weeks at some time during the year. Reserve soldiers are organized either into individual Army Reserve units called troop program units or as augmentees to active Army units as Individual Mobilization Augmentee. Reserve soldiers rotate through mobilizations to full-time duty periodically. There is also a group of reserve

soldiers referred to as the Individual Ready Reserve who typically do not drill but are subject to activation by the commander in chief. The Navy and Marine Corps reserves are structured with a Selected Reserve and an Individual Ready Reserve much like the Army. The Air Force Reserves serve in the Unit Program, in which they are required to report for duty at least one weekend a month and an additional two weeks a year. The Air Force also has Individual Mobilization Augmentee Reservists who are assigned to active-duty units to do jobs that are essential in wartime but do not require full-time manning during times of peace. They report for duty a minimum of one day a month and twelve additional days a year.

Use of the Reserve Components Today

The terrorist attacks on Sept. 11, 2001 with the following Global War on Terrorism have increased the use of all reserve component forces. Now when the Nation sends forces anywhere in the world, the reserve component plays a major part in operational success. Deployed reserve components provide critical combat, combat support, force protection and combat service support to the active component. This increase in use of the reserve component in deployed roles reinforces the need for constant increased readiness for mobilization. In order to understand how dental readiness is important to reserve component unit readiness, an understanding of each Services force rotation management system is important.

The Army uses the Army Force Generation Model (ARFORGEN) to assure the readiness of active and reserve units before deployment. The current Chief of Staff of the Army, General George Casey, said that the Army is “out of balance”. “The current operations have stretched and stressed our all volunteer force. The demand for forces,

capabilities, and soldiers exceeds supply, and continuing to sustain them at the level and frequency they are employed is a tremendous challenge."[44] His statement applies to both the active Component and the Army National Guard and Army Reserve. In order to balance the force, he has proposed ARFORGEN,[45] which is a systematic rotation plan to train, re-equip, and rest the Army. To increase the effectiveness of the Army reserve component and to improve their contribution to the active component, the Army has aligned each unit into synchronized training and force sustainment packages supported by manning, equipping and training processes.[46] ARFORGEN assigns units into one of three pools: 1) The Reset and Train, 2) The Ready, and 3) The Available. The cycle begins at the end of a deployment when a unit goes into the Reset and Train pool. While in this pool, the unit should not be redeployed until they move into the Ready pool. Once the unit is set it is moved into the Available pool ready and available for worldwide deployment. This process produces a cycle of trained, ready, and cohesive units. To qualify as Ready, units must be fully manned and properly trained, equipped and medically fit. Failure to meet medical or dental readiness criteria deters a unit's ability to be cycled through ARFORGEN, and prevents its timely deployment.

Like the rest of the Army, the Army Reserve and Army National Guard must address medical and dental readiness in their units as they cycle through the ARFORGEN, and become available for deployment. "The goal is to achieve a sustained, more predictable posture to generate trained and ready modular forces. Tailored for joint mission requirements, these forces preserve the capability to defend the homeland; to provide defense support to civil authorities; to deter conflict in critical

regions; to surge to conduct major combat operations when required; and are managed in a way that maintains the quality and overall health of our All Volunteer Force."[47]

The Air Force's Air and Space Expeditionary Force (AEF) plan provides a predictable schedule for rotation cycle for Air Force units, training, deploying and reconstitution of the Air Forces that leads to an effective and to high quality of life for Air Force much like the ARFORGEN, process does for the Army. Under the AEF concept, almost all of the Air Force – active, reserve and Guard – is divided into 10 AEF force packages, each with a cross-section of Air Force weapon systems drawn from geographically dispersed units.[48] In the late 1990s, five pairs of AEFs each with a 90-day deployment length for deployment within a 15-month training, deployment and reconstitution cycle. In 2004, the deployment length increased to 120-days within a 20-month cycle.[49] According to Colonel Deborah L. Hart, Mobilization Assistant to the Air Force Assistant Surgeon General for Dental Services, units are required to be ready to deploy. If a reserve airman fails to have the required DFC 3 treatment completed, it can lead to administrative discharge of the member.[50]

The Navy equivalent of the Army ARFORGEN and the Air Force AEF is the Fleet Response Plan (FRP). The FRP calls for six of the Navy's 12 aircraft carriers to be available for deployment within 30 days of notification and another two to be available in 90 days. Typically, the Navy will have two carriers based in the United States deployed overseas, in addition to one carrier permanently stationed in Japan. The FRP enables the Navy to continue to meet the demands of the combatant commanders for trained, flexible, and sustained forces with six carrier strike groups available on 30-days notice and an additional carrier strike group ready to serve within 90 days.[51] The Navy is

funded to achieve “6+1”—the ability to support deployment of six carrier strike groups within 30 days and one additional group within 90 days.[52]

The Marine Corps plan for the use of their component forces as laid out in the Marine Corps Posture Statement to the Senate Armed Services committee in February 2008 by General James T. Conway, Commandant of the United States Marine Corps, ”Policy changes allow the Marine Corps to use the Reserve forces as they were structured to be employed—to augment and reinforce the active component forces.”[53] He goes on to say, “Our fights thus far in Iraq and Afghanistan have been a Total Force effort—our Reserve forces continue to perform with grit and determination.”[54] The Marine Corps aim to implement a 1:5 deployment time to home station time ratio (meaning that for every unit of deployed time is followed by five units of time at home) for its’ reserve component in this war. [55]

The reserves have been activated and deployed on an unprecedented repetitive basis probably since World War II. Currently the United States has approximately 125,806 reserve component personnel activated for operational deployment; 92,255 are involuntary activations with the other 33,551 voluntary total personnel activated.[56] Since September 11, 2001, the reserve component has deployed 694,962 personnel. The Army Reserve and National Guard accounts for 461,577 of the total deployed soldiers and the Marine Reserve account for 52,352 of the total.[57] In this heightened operational tempo, readiness is important because of the next deployment on the horizon. Dental readiness is an important part of success in the unit’s next deployment.

Reserve Component Dental Readiness

Despite additional policy clarification, and hundreds of millions of dollars spent to increase dental readiness, the Services continue to be in a “just in time” readiness mode, meeting the published standard of 95 percent[58] dental readiness just prior to the operation or mobilization. This “just in time” approach to dental readiness has the potential for less than optimal outcomes.[59] It is often more expensive, reduces time spent training for deployment, and may necessitate suboptimal treatment short cuts that could lead to other dental issues during deployment.[60] “Just in time” treatment plans do not find DFC 3 conditions until after mobilization. “Currently, individuals who are cross-leveled (pulled from another, non-deploying unit) into a deploying unit to fill gaps are typically only 50 percent dentally ready, because they have not been on alert nor receiving needed treatment.”[61] Poor dental readiness is an ongoing issue and is an unnecessary distraction for training and preparation on the entire unit and may leave individuals and therefore entire units, not completely prepared for the complex asymmetric environment that they will face on the battlefield in these “'overseas contingency operations.”

The United States military and militaries from the beginning of the age of warfare have had to contend with illness and injury other than combat injuries, termed DNBI to their troops. In earlier times, epidemics of infectious diseases raged through fighting forces making them impotent. Modern preventative medical programs, such as immunizations, field sanitation, and dental readiness have been created to reduce the quantity of non-battle injuries. Dental emergencies result in lost duty time, decreased unit effectiveness, disruption of routine care, and hindrance to the military mission. The potential of dental emergencies to reduce combat effectiveness is still a major

concern.[62] Dental emergencies are well documented and studied, including a recent workshop in July 2006, on Prevention of Dental Morbidity in Deployed Military Personnel included attendees of U.S. Marine Corps, public health dentists from the U.S. Army, Navy, and Air Force, and personnel acquiring data to support the mission of the U.S. Navy and Marine Corps.[63] The objectives established prior to convening the meeting: I. Generate a comprehensive review of dental emergency experience in deployed military personnel, II. Exchange current information concerning Dental Classification procedures and dental morbidity rates in deployed military forces, III. Standardize terminology used to describe dental emergencies, dental morbidity, and operational readiness, IV. Discuss different methods used to capture information regarding dental emergencies occurring in deployed military forces, V. Explore areas of interest for future collaborative research.[64]

Maintaining a medically healthy Department of Defense force capable of providing commanders with personnel that are healthy, and physically fit to do their mission anywhere in the world has been a goal for the Assistant Secretary of Defense (Health Affairs).[65] The department has instituted several health prevention programs, which resulted in a military force better prepared to do its mission. Programs which reduce excess weight, control stress, increase smoking cessation, and improve dental fitness have been designed to improve the health of our most precious asset, the service member.[66] These programs have had a positive impact on the overall health of military personnel. Current DNBI rates for OEF/OIF are the lowest ever reported.[67] A second order effect is that these programs help to prevent injury and illness, reduce overall health care costs while increasing access for those who really do need care.

The effect of poor dental readiness may lead to an untimely dental emergency and a loss of duty time for missions, training, and an overall decrease in total unit effectiveness. The unexpected toothache is a mostly preventable urgent situation; the preventable toothache also plays a part in disruption to the treatment facility for routine dental care, which in turn decreases access to care for all other beneficiaries. It is a mostly preventable hindrance to the military mission of all Services and continues to confound all Services, especially the Army and the Marine Corps.[68] The military medical and dental systems of the Department of Defense exist to treat illness and injury, but more importantly to prevent and maintain a healthy, combat ready force.

Individual Dental Readiness

Despite the recognized importance of medical and dental readiness for the reserve component, especially in this time of frequent and repetitive mobilizations and deployment of the reserve forces, dental readiness in the reserve component remains poor; a recent Department of Defense briefing to the Service Surgeons General provides an example. (Table 1) Dated January 27, 2009 the table shows the DFC of the Services reserve components. DFC 1 and 2 are dental ready to deploy while DFC 3 and 4 are not. The Air Guard and the Air Force Reserve are reported as 91 percent and 86.6 percent dental ready to deploy, respectively. The Navy Reserve and Marine Corps Reserve are 92.8 percent and 77 percent dental ready to deploy, respectively; the Army National Guard and Army Reserve are 48.2 percent and 48.8 percent dental ready to deploy respectively.[69] (See Table 1)

The larger contribution to poor overall dental readiness for the Army and Marine Corps is the large numbers of DFC 4s service members. The Air Guard, Air

Force Reserve, and Navy Reserve are very close to the stated goal of 95 percent dental ready. The Army Reserve and National Guard and Marine Corps Reserve are not close to meeting these standards.[70]

Status	Army		Navy	Air Force		Marine Corps	Coast Guard
	Guard	Reserve	Reserve	Guard	Reserve	Reserve	Reserve
Class 1	12.9% 41,879	13.9% 25,403	32.7% 16,906	59.4% 53,273	50.3% 23,256	22.0% 7,502	54.6% 4,470
Class 2	35.2% 113,997	34.5% 62,950	60.1% 31,044	31.6% 28,388	36.5% 16,856	50.0% 16,999	28.6% 2,338
Class 3	11.6% 37,589	12.7% 23,212	2.3% 1,182	1.3% 1,181	1.7% 803	6.5% 2,195	2.9% 234
Class 4	40.2% 130,016	38.8% 70,877	4.9% 2,526	7.6% 6,776	11.2% 5,190	21.5% 7,332	14.0% 1,142
Total Force Denominator	323,481	182,442	51,658	89,735	46,224	34,028	8,184

Table 1. Individual Medical Readiness- Dental Element, Detailed, reserve components percent of Component Total Force, Q1 FY09 (as of January 27, 2009)[71]

Why is dental readiness an ongoing problem for portions of the Department of Defense, especially the Army and Marine Corps? Although oral health has long been acknowledged as a critical component of overall health and well-being, millions of Americans lack access to affordable dental health services.[72] Fear of the dentist or dental anxiety has also been identified as a barrier to treatment for many individuals in the dental literature.[73] Dental fear has many causes.[74] Dental fear has been ranked fifth among the most common fears.[75] Although men and women may be anxious about seeing the dentist, men often have a more serve form of fear of the dentist that actually deters them going to the dentist, allowing minor problems to become a major one.[76] This finding of fear of the dentist in males may explain why the services with a 17-25 year old males, particularly the Army and Marine Corps have such a low dental readiness rate.

Preventable problems grow over time requiring a greater intervention by the dentist. Patients who are very fearful of routine dental treatment have poorer oral health than those who are less anxious.[77] Dental fear perpetuates a vicious cycle[78] in which initial fear of visiting the dentist causes the individual to defer necessary minor care, allowing dental conditions to deteriorate to the point where procedures that are more intensive are necessary. Although the data are conflicting, this is some support for the notion that dental fear is more common in those without education beyond high school or equivalency and Rowe reports that those with more education are less fearful[79] So, dental fear may contribute to a mainly young male population with limited educated staying away from the dentist and thereby not being dental ready for deployment.

According to all the policies issued by Assistant Secretary of Defense (Health Affairs), it is the commander's responsibility to monitor medical readiness in his unit. "For the Reserve component, dental readiness is a commander and individual responsibility when not on active duty."[80] When the Army Selected Reserve Dental Readiness System was signed by the Assistant Secretary of the Army for Manpower and Reserve Affairs, Operations Order 08-150 issued by the US Army Reserve command states emphatically that dental readiness is a commander's program and requires emphasis to ensure success.[81]

Command Emphasis

Army Reserve and National Guard units along with Marine Corps Reserves seem to be having the most difficult time maintaining dental ready forces. This might reflect on a lack of command emphasis for dental readiness or something else. Data obtained from quarter one of fiscal year 2009 suggest the Air Force Reserve, the Air Guard and

the Navy Reserves are doing better, but are just short of meeting the goal of 95 percent dental readiness.[82] The Air National Guard and Air Force Reserves do not have as challenging a dental readiness problem as the Army reserve component. In several interviews and subsequent e-mail exchanges with Colonel Gary C. Martin, Consultant for Dental Public Health, United States Air Force Surgeon General, Tri-Service Center for Oral Health attributes the Air Guard and Air Reserve higher DFC 1 and DFC 2 rates to a strong command emphasis. The reserve unit commanders and the Chief of the Air Force Reserve have made it clear that in order to do their weekend drill, reserve component airmen need to be dental ready to deploy. Reserve component airmen in DFC 3 are given a limited time to complete required treatment or they can be administratively discharged for failure to comply if they do not get the treatment. Reserve component airmen in DFC 4 are be determined to be “not medically ready” or deployable. This determination codes them in the Air Force Military Personnel Data System so that they may not participate in drill or active duty training for pay or points.[83] Air Reservists or Air Guardsmen in DFC 3, cannot have orders issued to deploy while classified in DFC 3. Commanders have the authority to grant a waiver to allow deployment of a member in DFC 3, but this is extremely rare.[84] In the summary of her testimony to HASC, Oversight and Investigations in Support of the Military Personnel Subcommittee Colonel Deborah L. Hart, Mobilization Assistant to the Air Force Assistant Surgeon General for Dental Services reiterated these same compliance policies and added that they may be the most effective tools to steadily improve dental readiness.[85]

The Navy Reserve uses the Naval Medical Corps, Dental Corps and support personnel to perform medical and dental examinations for Navy Reservists to support their medical and dental readiness needs. Unlike the Army Reserve and Army National Guard, the Navy Reserve has at least one medical unit at each of its nine Naval Reserve Activities, which are units providing readiness support to Navy and Marine Corps Reserve units and are organized by geographic regions across the United States According to Captain Kerry J. Krause, Dental Corps United States Navy Reserve Affairs Officer, Bureau of Medicine and Surgery in his testimony before the HASC Oversight and Investigations in Support of the Military Personnel Subcommittee hearing "At present, Navy Reserve medicine is capable of providing adequate medical and dental readiness support for its Marine Corps and Navy Reservists."[86] It appears that according to the latest numbers the Marine Corps Reserves is further from meeting the 95 percent goal than the Navy Reserves.

Of all of the services, the large number of Army Reserve and National Guard members and Marine Corps reservists being deployed and the intensity of their mission to Iraq and Afghanistan could help explain the reason for the lower dental fitness rates among their members. Recent deployments have centered on the latest counterinsurgency doctrine. That is to move the forces away from the large bases and protect the population. This strategy could have the largest effect on access to dental facilities while deployed and access to personal hygiene. When the service members demobilize, a post-deployment dental examination is only one more obstacle in the way of finally getting home. Understanding some of these factors could explain why the

Army and Marine Corps have lower rates of DFC 1 and 2s and higher rates of DFC 3s and 4. (Table 1)

Programs Available to Improve Dental Readiness

In 1998, the Department of Defense (Health Affairs) issued a policy[87], which directed both the Active Component and Selected Reserve personnel to undergo a periodic dental examination on an annual basis. The same policy described the introduction of the TRICARE Selected Reserve Dental Program (TSRDP), which provides a mechanism for the selected reserve to achieve a similar 95 percent readiness goal[88] as outlined for the active component. The TSRDP or TRICARE Dental Program (TDP) provides access to readiness oriented care for insured members of the Selected Reserve. The TDP has subsequently been made available for the National Guard members. The TDP is one of several programs, which may improve dental readiness in all reserve component service members.

In order to understand some of the available programs for the reserve component dental readiness, they will be listed chronologically when they are available to reserve component service members: predeployment, during deployment or post deployment. Prior to activation and deployment there are several dental programs available to reserve component service members which can improve dental readiness, the programs include each Service's basic training dental programs, the TDP, early Tricare eligibility, the Army Selected Reserve Dental Readiness System (ASDRS) the Reserve Health Readiness Program (RHRP), the Army National Guard medical Readiness Days program.

Army recruits have high levels of dental disease upon entry. The 2000 Tri-Service Center for Oral Health Studies reported that 42 percent of incoming Army recruits had at least one dental condition that made them nondeployable.[89] In 2002, the Army Dental Command (DENCOM) implemented the First Term Dental Readiness (FTDR) program providing dental treatment for all soldiers at their Initial Entry Training (IET) or Advanced Individual Training (AIT) sites to address this poor dental readiness in recruits. This program is for all AIT and IET members Active, Army Guard and Army Reserve. Addressing oral health needs early in training establishes a baseline of dental health for the Army.[90] As is done in the Navy, additional dental personnel are placed at basic training sites to treat this population. The goal for this initiative is 95 percent of soldiers graduating from IET or AIT dental ready. Currently, 71 percent of soldiers leaving IET and AIT are ready.[91] The challenges for these sites to increase dental readiness even more are the constraints in the existing treatment facilities applies to both finding the time in the new recruit's tightly scheduled calendar to attend dental treatment appointments and the length of complex dental treatment plans.

The Navy employs a successful program at Navy and Marine Corps basic training sites for the recruits with the goal of increasing dental readiness to 95 percent of boot camp graduates.[92] Over the past 3 years, incoming Navy and Marine Corps recruits have entered boot camp with an average dental readiness of 29 percent.[93] The Navy has maintained dental readiness rates for boot camp graduates at the 80 percent rate. Prior to 2002, readiness percentage across the Navy has been in the mid 90's or above.[94] Since 2002, the readiness rate has fallen to 86-87 percent, as they have had to shift resources to focus on personnel who are getting ready to deploy.[95]

Tricare Dental Program

The Tricare Dental Program (TDP) is an optional benefit offered to selected reservists and the National Guard. Although mainly offered as a health benefit, wide spread participation in this program would also improve reserve component dental readiness. Participation in private dental insurance plans offered by the reserve component members' civilian employer would have a similarly secondary benefit on dental readiness. In various surveys, including the Status of Forces Survey of Reserve Component members, approximately 70 percent of reservists have responded that they have some form of dental insurance provided by their civilian employer.[96] Participation in the TDP has been very low[97] perhaps related to the service member's responsibility for premiums and treatment co-payments. Army units mobilized after implementation of the TDP continue to arrive at deployment stations with 14-36 percent of their personnel in DFC 3. Voluntary cost sharing programs have not improved the dental readiness rates.

National Guard and Reserve members are eligible to enroll in the TDP when they are not on active duty for more than 30 consecutive days. If a National Guard or a Reserve member enrolled in the TDP is called or ordered to active duty for more than 30 consecutive days, he or she will automatically be disenrolled from the program during the period of activation and automatically re-enrolled upon deactivation.[98] The cost of TDP is shared between the Government and the service member. Currently the government assumes 60 percent of the program cost. The service member currently pays $12.12 a month in premiums.[99] In addition, service members are required to pay a cost share for the dental services rendered. Most of the service members copayments

are between 20 and 50 percent of allowable charges. Finally, the yearly benefit cap is $1200.00.[100] The most recent sign up rates for the Army National Guard is 7.83 percent and for the Army reserve is 5.84 percent.[101] A common perception among junior enlisted reserve component members is that the insurance is costly. Further, when the Reservists and Guardsmen do purchase the insurance, many areas in the United States have small network of dental providers limiting service members choice.[102] The Navy has also identified a perception that the cost of the TDP is prohibitive.[103]

Early Tricare Eligibility

Reserve component members who are ordered to active duty on a delayed basis may be eligible for dental benefits under the Tricare program while waiting to report. Reserve component members with deployed effective date active duty orders have the same dental benefits as active duty members. The member's service personnel office will inform members if they are eligible for pre-activation benefits when they receive their delayed effective-date active duty orders.[104] Reserve component members who were enrolled in the TDP prior to receipt of delayed-effective-date active duty orders will become eligible for the same dental services provided to active duty service members.[105] Reserve component members close to military bases may receive dental care through their local military Dental Treatment Facilities (DTF). Reserve component members in locations remote from a military DTF are covered for dental care via the Tri-Service Remote Dental Program, administered by the Military Medical Support Office (MMSO).[106] Like the Army, the Navy uses contract dentists, and encourages reserve members to sign up for the Tricare Dental Program. To maintain their readiness goals with fewer Reserve and Active Dental Corps personnel, they also have increased the

use of private sector dentists through the Military Medical Support Office (MMSO) program. MMSO is a funded program used to refer a patient to private sector care when the military treatment facilities do not have the capacity to treat a patient in the required time. MMSO is a part of the TRICARE Management Agency, which is a component of the Military Health System. MMSO authorizes and reimburses civilian dentists for treatment. This shift in care to private sector has increased the MMSO costs over the past four years from $3.7M to 2004 to $34M in 2007.[107] This program has limited usefulness because of lack of excess providers and equipment to treat the potential large number of early TRICARE beneficiaries using existing staffing and space available at military DTFs.

Army Selected Reserve Dental Readiness System

The second prong of the Army's answer to improve overall dental readiness for the Army reserve component after FTDR is the Army Selected Reserve Dental Readiness System (ASDRS).[108] The ASDRS is outlined in an Operation Order signed by the Assistant Secretary of the Army for Manpower and Reserve Affairs on 3 September 2008 and applies to all soldiers in the Selected Reserve. The ASDRS enables reserve component commanders to improve the overall dental readiness at their home station.[109] Commanders will be held responsible through the Unit Status Reporting process for ensuring their soldiers complete the annual dental examination and required DFC 3 treatment.[110] The ASDRS system allows reserve component units to pay for dental examination and DFC 3 treatment to the Army SELRES soldiers outside their alert status. The goal is to achieve the 95 percent dental readiness in support of individual medical readiness standards prior to arriving at the mobilization platform. This

operations order from the US Army Reserve command mandates command emphasis should improve the Army SELRES dental readiness and deployability. The goal as stated in the policy will eliminate the need for the “just in time “dentistry, which is inefficient, time sensitive and difficult to manage effectively. ASDRS enables the reserve component commanders to achieve dental and improved preventive dental practice at home station, prior to arrival at the mobilization platform. ASDRS is not currently funded in the Program Objective Memorandum (POM) budget until fiscal year 2010.The money to pay for ASDRS for the current fiscal year 2009 is a carve out of the existing budget. The Army Reserve Component requested $110 million for the ASDRS in fiscal year 2009.[111] These funds are for purchasing dental readiness care outside of alert for mobilization, base program.[112]

Reserve Health Readiness Program

The Assistant Secretary of Defense (Health Affairs) runs a program named the Reserve Health Readiness Program (RHRP), which established a network of private sector dental resources to support reserve component dental readiness. This program was created first under a different name in 2002 when the Department of Defense discovered that poor dental health and other medical problems could prevent Reservists and Guardsmen from being activated or deployed and Congress mandated legislation requiring reservists to undergo periodic physicals and dental examinations. The RHRP works by providing contracted civilian medical support services to reserve units to help them meet the medical and dental readiness.[113] The reserve component Soldier may receive an annual dental examination at no cost regardless of alert status, but can only receive DFC 3 treatment at no cost upon alert or mobilization status, thereby reducing

the incentive to improve their dental health.[114] The RHRP administered in conjunction with the Department of Defense and central contracted medical services to support the medical readiness mission.

The Army National Guard provides dental screening and treatment services through each state medical detachment and a variety of local service contracts similar to the Reserve Health Readiness Program (RHRP). This program was created to assist the reserve component, achieve readiness when increased deployment requirements severely affected reserve component health readiness.

Mobilization Paid "Medical Days"

"Active component Soldiers do not take unpaid leave to go to the dentist; nor should Guardsmen."[115] A new suggested program found in the testimony of in the Findings and Recommendations of the House Armed Services Subcommittee on Oversight and Investigations in Support of the Military Personnel Subcommittee instituting two medical readiness days per year would allow reserve component soldiers to go on active duty in order to get medical or dental care completed without loss of income.[116] The days can be pooled, meaning that if one soldier does not need all or some of the annual two-day allotment, a commander may transfer that allotment to another soldier in the unit, who may require additional days of treatment.[117] This proposal is designed to give two Medical Days- during predeployment. This may prove to be a useful tool when the Guardsman cannot take time off from their job to get the required routine medical and dental examination, treatment and tests in order for them to be ready to deploy. The ability to provide two medical readiness days per Soldier would be a powerful incentive for the Soldier to complete readiness requirements, as

well as a tool for our commanders to ensure compliance. It would further improve overall unit readiness by removing medical readiness as a competitor for training days.[118] This program has potential to help improve dental readiness as long as the service member uses the time wisely and commanders do not monopolize that time with some other "mandatory" predeployment training or event. Although this Medical Days program is authorized, it is not presently funded by any of the Services.

"Decade of Health"

In 2007, the Army National Guard launched an education initiative and called it "Decade of Health." Its purpose is to provide health promotion advice to and to draw attention to different topics each succeeding year for its members. The first year focused on dental readiness with an oral health awareness outreach. On the Army National Guard website attention is given to the five big Medical Readiness issues: 1. Dental Health, 2. Mental Wellness, 3.Weight Management, 4. Injury Prevention, and 5. Tobacco Cessation.[119] Keeping preventive health on the forefront is much less costly then having to perform treatment due to neglect. Education programs such as these are valuable for keeping ideas for prevention in the present.

Local National Guard Programs

The HASC Subcommittee on Oversight and Investigations in Support of the Military Personnel hearing in April 2008 found that, "The Guard currently offers states a variety of options to improve oral health upon alert. States coordinate their own treatment programs, tailored to meet specific unit needs, using some combination of available programs, and may request federal funds from the National Guard Bureau."[120]

Funds are requested by the state once a unit has been alerted. They are primarily used for the treatment of soldiers who are in a DFC 3 status.[121]

Dental Demobilization Reset Reserve Program

The Dental Demobilization Reset (DDR) program is the Army's third active program to improve the readiness of the SELRES. The DENCOM started the DDR program in July 2008 for demobilizing soldiers as they arrive at the demobilization platform. Under DDR, reserve component soldiers receive a dental examination and limited DFC 3 care at the demobilization station dental clinic. It works by having active duty dentists performing a complete dental examination to include radiographs for the returning soldier. The dental examination identifies existing necessary dental work that was not completed while the soldier was deployed. The treatment program focuses on soldiers who need immediate DFC 3 care. The returning soldier, however, will be informed of all other dental treatment and preventive care needs. Either that care will be provided at the demobilization clinic, time and space permitting, or the soldier can seek care using a voucher issued through the DDR program for use at his or her hometown dentist. Taking care of the immediate dental care at the time of demobilization should have a positive effect on the service member when it comes time for his next activation or mobilization.

Veterans Affairs Dental Clinics

Another benefit that many demobilizing reserve component service members may use is the Department of Veteran Affairs (VA) dental benefit. Veterans who serve on active duty 90 days or more are eligible for one-time dental examination and treatment if their certificate of discharge does not indicate they received necessary

dental care 90 days prior to separation and if they apply for a the dental examination within 180 days after separation. After this initial benefit, the VA provides further dental examinations and treatment to veterans with service-related dental conditions.[122] Although this benefit is available to most separating reserve component service members, the utilization is very low, less than 10 percent of those eligible.[123]

This would serve the purpose of a dental reset for the reservist at no cost to them. If more discharging Reserve and National Guard used this benefit, they could use the VA system to set their dental readiness at a DFC 1 after their deployment and transition time. In lieu of other dental treatment, this would make it easier to be ready to deploy by the time their unit is called again for service to this nation.

Dentistry in this day with the latest technical advances has led to an emphasis on prevention and education. Dentistry is now delivered with newer, more effective local anesthetics, advances in pain control and newer materials and procedures performed with a greater skill and accuracy with less trauma, taking less time. Despite all these advances, many patients still continue to harbor negative perceptions of dental care and tend to remember only the negatives of prior oral health care experiences and experience the same level of fear and anxiety today. Dentists and their staff receive little, if any, education in the management of the anxious patient, even though; this aspect of oral health care clearly contributes to positive dental experiences.[124] [125]

Conclusions & Recommendations

To ensure the readiness capacity of the reserve component forces, a more concerted effort is needed to develop and build on the dental readiness successes already achieved. As Representative Vic Snyder (D-Arkansas), Chairman of the

Oversight and Investigations in Support of the Military Personnel Subcommittee of the HASC hearing on Challenges Associated with Achieving Full Dental Readiness in the reserve component stated, “The reserve component is transforming from a strategic to an operational reserve. We need to give our men and women in the Guard and Reserve the tools they need to take up this mission.”[126] He went on to describe the factors that can affect the success of their mission is “…the health of every one of their members; their individual medical readiness.”[127] “Oral health is an often overlooked, but extremely important aspect of overall pre-deployment readiness.”[128] Improving dental readiness rates in the reserve component will require a combination of command emphasis, accountability on the part of individual service members, and possibly programmatic changes.[129]

There are several programs available to meet the dental readiness needs of the reserve component. Some of these programs are more effective than others. It is a matter of education and utilization of the resources available to affect the goal. Individual responsibility, education, and knowledge that dentistry in this modern age is preventive oriented and can be pain free. There are programs available to overcome poor dental readiness in our reserve component forces. All of the Services have programs and different resources that work to improve the dental readiness of their members. Some of these programs should be made available and used by each of the Services to improve the dental readiness of their National Guard and Reserve forces. Education about these programs and the actual value of keeping your mouth healthy in initiatives such as the “Decade of Health of the National Guard” program. The Navy and Marine Corps aggressively diagnose and treat sailors and Marines with dental disease

at their basic training sites. The Army's FTDR is similar but does not get the respect it deserves when it comes time to finding space in the recruit's calendar to have dental work done. A concerted effort must be made to have time available for early treatment of all service members at basic training sites. The less than subtle approach that the Air Guard and Air Force Reserve use of not allowing drill for those who are not dental ready. They may not drill or earn points for longevity, but they are still subject to activation with a waiver if called upon. A command directive from the chief of the respective reserve component making medical readiness a prerequisite for drilling should solve the problem. The individual unit commanders reserve component members should continue to monitor their units' readiness monthly.

Post deployment dental care reset can be a start to fixing the predeployment problems. COL Mark Bodenheim, U S Army Dental Corps, Chief, Reserve Component Mobilization and Demobilization Operations, U.S. Army Dental Command; DENCOM in his testimony to the House Armed Services Commission subcommittee stated "…resetting Army reserve component dental readiness during demobilization has the potential to improve baseline readiness of the entire population by approximately 10 percent."[130] When service members have all treatment completed, and visit their hometown dentist for the routine preventive services, it is less likely for them to experience any new DFC 3 conditions found when they come back up for another mobilization. Use of the Veterans Affairs benefit for those who live near and desire treatment from that resource would be a cost effective for that veteran.

There is growing evidence that we can effectively improve the dental readiness of National Guard and Reserves if we try harder and pursue options to be done in the

reset or ready phase prior to mobilization. Primarily there has to be a commitment and a sober command emphasis on overall unit readiness. The other three Services should look at the Air Force command directives to discourage those who are not medically fit from drilling and earning retirement points, but still be subject to activation and deployment. Second, each service member must take personal responsibility and accountability for his or her own health and individual medical readiness. This includes preventive measures such as daily oral care and routine visits for preventive care with their hometown local dentists. Preventive measures such as routine cleanings, dental sealants and home care can prevent most dental disease and keep it from getting worse. Each member should be encouraged to enroll and use available resources such as private insurance. The choice our reserve component members have is the insurance from their employer at work, or the use of the government subsidized Tricare Reserve Dental Insurance. The important factor then is to use the benefits of an examination twice a year along with the preventive services offered at no more cost to prevent dental disease. Then when disease is first discovered, use the insurance to pay for the covered service. Doing those things would make the mobilization process much quicker. Then, during mobilization, seek routine preventive care with the local military dental clinics as time and mission permits. Upon demobilization, use of the RHRP, ASDRS, and the VA separation benefits, to get away from the “just in time” dental examination and necessary treatment that plagues the Army and Marine Corps at the mobilization stations.

Since dental readiness is an important issue to overall readiness in the National Guard and Reserves and since dental readiness has not been achieved by the Army,

the Services should ask Congress to consider pay for readiness. One finding and recommendation from the House Armed Services Subcommittee on Oversight and Investigations in Support of the Military Personnel Subcommittee final report recommends expanded TRICARE Dental Program where the Department of Defense could a) pay the full premium for reservists (as it does with the active component with a no cost dental care by the services) or provide tiered premiums to reduce the monthly cost for junior enlisted personnel, or b) reduce or eliminate the cost shares for preventative and restorative procedures in order to encourage reserve component personnel to enroll in TDP.[131] The Services could also institute a yearly bonus for those SELRES who are medically fit eligible for worldwide deployment. Reservist could earn extra money in the form of a bonus to be DFC 1 or DFC 2. A good dollar amount might be the equivalent of the yearly rate for the dental insurance premium. Those who have their own insurance or pay their hometown dentist fee for service could use that money as they wish. The bonus would be paid annually only after the dental examination was certified. The payment would be made once a year following the yearly dental examination. Fund the two training medical days a year for medical readiness. During mobilization, encourage the use of preventive services and routine care at DTFs. At the demobilization site, Services perform a complete demobilization oral examination and provide urgent treatment, and use private sector care for treatment by hometown care providers for less urgent treatment.

This paper concludes with insights based on existing programs that are in place and available for use by the Reserve and National Guard forces. They have been the work of the individual Services, Congress, the Department of Defense and legislation

already made available to help with the problem of lack of dental readiness in our reserve forces. The take home points include a better understanding of the nature of dental readiness itself, how the individual Services have their own system of ready rotation to deliver forces for the combatant commanders and finally a way ahead for greater access to dental treatment for those forces. The imperative of command emphasis cannot be overlooked and is the key to making any of these programs a success, as witnessed by the Air Force's success. This nation owes all those warriors who have raised their hand in defense of freedom a huge debt. One small part is adequate dental care to relieve potential pain and suffering and to prevent a potential negative affect to the mission of their unit. Our citizen-soldiers, sailors, airmen and Marines of the reserve component and National Guard deserve this benefit and should be encouraged to use it.

Endnotes

[1] U.S. Department of Health and Human Services. "Oral Health in America: A Report of the Surgeon General-- Executive Summary". Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

[2] Rose, Joan, B. "Future Health Assessment and Risk-Management Integration for Infectious Diseases and Biological Weapons for Deployed U.S. Forces," in Strategies to Protect the Health of Deployed: Assessing Health Risks Deployed U.S. Forces, (Washington DC: National Academy Press, 2000), 59.

[3] U.S. Department of Defense, Policy on Oral Health and Readiness, Health Affairs Policy 06-001 (Washington, D.C.: U.S. Department of Defense, 9 January 2006).

[4] Vic Snyder, (D-Ark), U.S. Congress, House of Representatives, House Armed Services Subcommittee, Opening Statement: Reserves' Dental Services Readiness: Dental Readiness in the Reserve Component: Hearings before the Special Subcommittee on Oversight and Investigations in Support of the Military Personnel, 110th Cong., 2nd sess., April 23, 2008, (accessed 16 December 2008).

[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Ibid.

[10] Ibid.

[11] Ibid.

[12] Findings and Recommendations of the House Armed Services Subcommittee on Oversight and Investigations in Support of the Military Personnel Subcommittee re: Dental Readiness in the Reserve Component 110th Cong., 2nd sess., April 23, 2008, 1. (accessed 16 December 2008).

[13] Ibid.

[14] Ibid., 2.

[15] Mark B. Bodenheim, Presentation to the House Armed Services Subcommittee on Oversight and Investigations United States House of Representative Subject: Dental Readiness in the Reserve Component testimony, 110th Cong., 2nd sess., April 23, 2008, (accessed from internet 29 September 2008).

[16] Mark B. Bodenheim COL, DC, USAR, "Army Reserve Components Dental Readiness — A Historical Review Since the First Gulf War," U.S. Army Medical Department Journal, January-March 2006, 27., (accessed from internet 30 September 2008).

[17] U.S. Department of Defense, Individual Medical Readiness, Department of Defense Instruction 6025.19 (Washington D.C.: U.S. Department of Defense, 3 January 2006), 4.

[18] Ibid., 1.

[19] U.S. Department of Defense: Health Affairs Policy 97-020: Policy for Standardization of Dental Classifications. (Washington, DC, Department of Defense,19 December 1996).

[20] U.S. Department of Defense: Health Affairs Policy 98-021 Policies on Uniformity of Dental Classification System, Frequency of Periodic Dental Examinations, Active Duty Overseas Screening, and Dental Deployment Standards, (Washington, DC, Department of Defense,19 February1998).

[21] Bodenheim, "Army Reserve Components Dental Readiness —,28.

[22] U.S. Department of Defense: Health Affairs Policy 02-011: Policy on Standardization of Oral Health and Readiness Classifications. (Washington, DC, Department of Defense, 4 June 2002).

[23] U.S. Department of Defense Instruction 6025.19 , Individual Medical Readiness.

[24] U.S. Department of Defense: Health Affairs Policy 06-001, Policy on Oral Health and Readiness, (Washington, DC, Department of Defense, 9 January 2006).

[25] Jeffrey Rodden, Capt., DC USN (Ret.) "Dental Emergency Visits of the Marine Corps Personnel," Military Medicine, Vol. 160, (November 1995).

[26] Wayne M. Deutsch CDR, DC USN, "Dental Events during Periods of Isolation in the U.S. Submarine Force," Mil Med., Vol. 173, January Supplement 2008, 37. in IngentaConnect (accessed 21 November 2008).

[27] Bodenheim testimony to the HASC on Oversight and Investigations. 3.

[28] Ibid.

[29] Chaffin, Jeffrey; Moss, David, Mil Med.," Review of Current U.S. Army Dental Emergency Rates," Volume 173, Supplement 1, January 2008 , 23 in IngentaConnect (accessed 21 November 2008).

[30] Andrew K. York, Capt, DC USN; David L. Moss, COL, DC USA; Gary Martin Col, USAF "*DCA Longitudinal Study of Dental Experience during the First Four Years of Military Experience*" Mil Med., Volume 173, Supplement 1, January 2008, 39. in IngentaConnect (accessed 21 November 2008).

[31] Bodenheim, "Army Reserve Components Dental Readiness —," 27.

[32] Ibid.

[33] Rhem KT. "New TRICARE Program to Boost Dental Readiness of Reserves," American Forces Information Service News Articles, March 21, 2001.

[34] Bodenheim, "Army Reserve Components Dental Readiness —," 27.

[35] U.S. Department of Defense: Health Affairs Policy 02-011.

[36] "Executive Summary" Military Medicine, Volume 173, Supplement 1, January 2008 , pp. ix-xiii(1) Dental Classification and Risk Assessment Workshop hosted by NIDBR. The workshop was held from July 11 to 13, 2006 in Great Lakes, Illinois in IngentaConnect (accessed 20 March 2009).

[37] U.S. Department of Defense: Health Affairs Policy 02-011: Policy on Standardization.

[38] Title 10 of the United States Code, Subtitle E, PART I, CHAPTER 1003, § 10102 http://www.law.cornell.edu/uscode/10/ usc_sec_10_00010102----000-.html (accessed 20 March 2009).

[39] Title 32 of the United States Code, CHAPTER 1, § 103, http://www.law.cornell.edu/ uscode/uscode32/usc_sec_32_00000103----000-.html, (accessed 20 March 2009).

[40] Title 10 of the United States Code, Subtitle E, PART I, CHAPTER 1003 §10105.

[41] Title 32 of the United States Code, CHAPTER 3, § 314, http://www.law.cornell.edu/uscode/search/display.html?terms=adjutant&url=/uscode/html/uscode32/usc_sec_32_00000314----000-.html , (accessed 20 March 2009).

[42] Ibid., § 328.

[43] Title 10 of the United States Code, Subtitle E, PART I, CHAPTER 1003, § 10103.

[44] U.S. Department of the Army, 2008 Army Posture Statement (Washington, D.C.: U.S. Department of the Army, February 2008), B-5.

[45] U.S. Department of the Army, Army Campaign Plan 2008, PLANORD, DAMO-ZT 29 Feb 08 publication, Statement (Washington, D.C.: U.S. Department of the Army, February 2008).

[46]Jack C. Stultz, *The United States Army Reserve 2008 Posture Statement* , Presented to the Air and Land Forces Subcommittee of the House Armed Services Committee Second Session, 110th Congress 2nd sess. (Washington, DC: U.S. Department of the Army, 2008), 3.

[47] U.S. Department of the Army, 2007 U.S. Army Posture Statement, Addendum H (ARMY FORCE GENERATION) (Washington, D.C.: U.S. Department of the Army, 2007); available from http://www.army.mil/aps/07/addendum_print/h.html; (Internet; accessed 03 November 2008).

[48] Aerospace Expeditionary Force (AEF) Air and Space Expeditionary Task Force (ASETF) (Formerly Air Expeditionary Force) Global Security Website http://www.globalsecurity.org/military/agency/usaf/aef-intro.htm. (accessed 21 December 2008).

[49] Ibid.

[50] Deborah L. Hart, COL, DC, Air Force, Testimony to the committee on Armed Services Subcommittee on Oversight and Investigations United States House of Representatives, Subject: Dental Readiness in the Reserve Component, presented 23 April 2008, (accessed from internet 29 September 2008).

[51] Donald C. Winter, Michael G. Mullen, James T. Conway, Testimony at the hearing of the House Armed Services committee United States House of Representatives; Subject: "Fiscal Year 2008 Budget Request for the Department of the Navy", Washington, D.C.(accessed from internet 03 November 2008).

[52] Donald C. Winter, Department of the Navy 2008 Posture Statement: FY 2009 Posture Statement http://www.navy.mil/navydata/people/secnav/winter/2008_posture_statement2.pdf, Presented to the House Armed Services Committee 110th Congress, 2nd sess. 6 March 2008 (accessed from internet 03 November 2008), 9.

[53] James T. Conway, Implications of Iraq Policy on Total Force Readiness, Presented to the House Armed Services Committee 110th Congress, 1st sess. 23 January 2007 (accessed from internet 04 November 2008).

[54] James T. Conway, Marine Posture Statement 2008, Presentation to the Senate Armed Services Committee 110th Congress, 2nd sess. 28 February 2008 (accessed from internet 03 November 2008), 4.

[55] Ibid., 2.

[56] Reserve Components NOBLE EAGLE / ENDURING FREEDOM / IRAQI FREEDOM Unique SSAN Activations as of: February 17, 2009. http://www.defenselink.mil/news/Feb2009/d20090217ngr.pdf (accessed 16 March 2009).

[57] Ibid.

[58] DOD Health Affairs Policy 02-011: Policy on Standardization of Oral Health.

[59] Findings and Recommendations of the HASC Subcommittee 23 April 2008, 2.

[60] Ibid.

[61] Ibid.

[62] B G Bishop, J C Donnelly, "Proposed criteria for classifying potential dental emergencies in Department of Defence military personnel." Mil Med., 1997 Feb ; Volume 162 (2):130-5

[63] Executive Summary, Mil Med., 172, 10:ix–xiii, 2007. Volume 173, Supplement 1, Jan 2008 p. ix., IngentaConnect (accessed 21 November 2008).

[64] Ibid.

[65] U.S. Military Health System Home Page, http://www.health.mil/StrategicPlan/Default.aspx (Accessed 6 January 2009).

[66] Ibid.

[67] 2008 MHS Stakeholders' Report p. 7. http://www.tricare.mil/stakeholders/default.cfm (accessed December 2008).

[68] Snyder, Chairman, HASC on Oversight and Investigations in Support of the Military.

[69] Department of Defense briefing to the Service Surgeons General Slide 16 in Briefing "DOD Balanced Scorecard Individual Medical Readiness titled IMR Reserve Component Q1 FY09," dated 27 January 2009.

[70] Ibid.

[71] Ibid.

[72] U.S. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

[73] Michelle Rowe (2005). Dental Fear: Comparisons between younger and Older Adults. American Journal of Health Studies, 20(3/4), 219-224. Retrieved November 3, 2008, from Research Library database. (Document ID: 1192252331), 219.

[74] Ibid., 220.

[75] Ibid.,219.

[76] Ibid., 220

[77] Ibid., 220.

[78] Ibid., 219.

[79] Ibid., 220.

[80] Department of Defense (Health Affairs) 06-001 policy on Oral Health and Readiness.

[81] DASG-HS-DC Subject Army Reserve Component (RC) Readiness.

[82] Slide 16 in Briefing of DOD Balanced Scorecard Individual Medical Readiness titled "IMR Reserve Component Q1 FY09."

[83] E-mail correspondence Martin, Gary C. Colonel, USAF, DC Consultant for Dental Public Health, USAF/SG Tri-Service Center for Oral Health.

[84] Hart, Presentation to the committee HASC, 6.

[85] Ibid.

[86] Michael L. Cowan Testimony before the Subcommittee on Total Force House Armed Services Committee Hearing, United States House of Representatives regarding Defense Health Programs March 18, 2004 http://www.globalsecurity.org/military/library/congress/2004_hr/04-03-18cowan.htm (Accessed 17 November 2008).

[87] Department of Defense for Health Affairs policy 98-021.

[88] Ibid.

[89] Chaffin, Jeffrey, "*First-Term Dental Readiness*," Mil Med., 171, 1:25, 2006 in IngentaConnect (accessed 21 November 2008).

[90] Ibid.

[91] Jim Daniels, COL, Dental Corps Staff Officer, Office of the Army Surgeon General, interview by author, February 2009.

[92] Kerry J. Krause Statement and Presentation to the committee on Armed Services Subcommittee on Oversight and Investigations United States House of Representative Subject:

Dental Readiness in the Reserve Component testimony, 110th Cong., 2nd sess., April 23, 2008, (accessed from internet 29 September 2008).

[93] Ibid., 2.

[94] Ibid.

[95] Ibid.

[96] Gary C. Martin, COL, DC, Air Force, Prepared Statement and Presentation to the committee on Armed Services Subcommittee on Oversight and Investigations United States House of Representative Subject: Dental Readiness in the Reserve Component testimony, 110th Cong., 2nd sess., April 23, 2008, 2, (accessed from internet 29 September 2008).

[97] Ibid., 3.

[98] Tricare benefit site www.tricaredentalprogram.com/tdptws/enrollees/answers/activation_faq.jsp , (accessed 10 Mar 2009).

[99] Tricare Benefit Website http://www.tricaredentalprogram.com/tdptws/enrollees/premiums/reserveguard.jsp , (accessed 10 Mar 2009).

[100] Tricare Benefit Website http://www.tricaredentalprogram.com/tdptws/enrollees/benefits/maximums.jsp, (accessed 10 Mar 2009).

[101] Briefing slide titled “Covered Lives-Army Reserve and Guard 20081001-20090101” Tricare Management Agency, Office of The Surgeon General data” dated 2009 0110.

[102] Krause, Presentation to the House Armed Services Subcommittee, 3.

[103] Ibid., 3.

[104]. Tricare Benefit Website www.tricare.mil/mybenefit/home/Dental/ActiveDuty (accessed 10 Mar 2009).

[105] Tricare Benefit Website Beneficiary Website www.tricaredentalprogram.com/tdptws/info/early-tdp-enrollment.jsp , (accessed 10 Mar 2009).

[106] Tricare Benefit Website Beneficiary Website www.tricare.mil/mybenefit/Glossary.do?F=M, (accessed 10 Mar 2009).

[107] Krause, Presentation to the House Armed Services Subcommittee, 3.

[108] U. S. Army Office of the Surgeon General, Information Paper DASG-HS-DC Army Reserve Component (RC) Dental Readiness,13 February 2009.

[109] U.S. Department of the Army, Army Selected Reserve (SELRES) Dental Readiness System (ASDRS), SAMR-MHO 4 Sep 2008 Assistant Secretary of Army of Manpower and Reserve Affairs (Washington, D.C.: U.S. Department of the Army, 3 September 2008).

[110] U. S. Army Office of the Surgeon General, Information Paper DASG-HS-DC Army.

[111] Ibid., 1.

[112] Ibid.

[113] http://www.hooah4health.com/deployment/benefits/fedsheal.htm, (accessed 21 November 2008).

[114] Bodenheim, Presentation to the House Armed Services Subcommittee, 11.

[115] David Sproat, COL, MC, Statement and Presentation to the committee on Armed Services Subcommittee on Oversight and Investigations, United States House of Representative, Subject: Dental Readiness in the Reserve Component testimony, 110th Cong., 2nd sess., April 23, 2008, (accessed 16 December 2008).

[116] Findings and Recommendations of the HASC Subcommittee 23 April 2008, 3.

[117] Ibid.

[118] Sproat, Statement and Presentation to the House Armed Services Subcommittee 3.

[119] Army National Guard "Decade of Health" Home Page, http://www.decadeofhealth.com/reference (accessed 21 November 2008).

[120] Snyder, Chairman, HASC on Oversight and Investigations in Support of the Military.

[121] U.S. Departments of the Army and Air Force National Guard Bureau, NGB-ARS Medical and Dental Mobilization Readiness, Pamphlet 2009. (Arlington, VA)

[122] http://www.oefoif.va.gov/healthcarebenefits.asp (accessed 3 November 2008).

[123] Conversation with Department of Veterans Affairs, Undersecretary for Dental Health, Dr. Timothy Ward, 12 August 2008.

[124] Perez, B., Kaplan, R., & Stabholtz, A. (1997). The influence of a patient-management course to dental hygiene students on the dental anxiety of their patients. Journal of Dental Education, 61(4), 368.

[125] Rowe, Dental Fear: Comparisons between Younger, 220.

[126] Snyder, Opening Statement of HASC Oversight and Investigations Subcommittee Hearing 23 April 2008.

[127] Ibid.

[128] Ibid.

[129] Ibid.

[130] Bodenheim, Presentation to the House Armed Services Subcommittee, 12.

[131] Findings and Recommendations of the HASC Subcommittee 23 April 2008, 3.